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ABSTRACT

Intended primarily for state and local health and education staff, the guide considers using the school setting as one resource in the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. Chapter I introduces the EPSDT program and describes its services to Medicaid eligible children. The chapter also sets forth school health goals as well as the health needs of the school aged child. The incidence of disabilities in this population is noted, and the intervention role of EPSDT emphasized. State operation and outreach activities are considered. Chapter II focuses on school roles in EPSDT, including outreach case management, and service delivery. Procedural steps in implementing EPSDT are the concerns of Chapter III, including local level orientation, role of a steering committee, and planning. Chapter IV reviews examples of successful partnerships between local educational systems and EPSDT programs; and highlights the school's role in outreach, screening, and as full range provider. Extensive appendixes include lists of state and regional EPSDT coordinators and guidelines for interagency agreements between public health and EPSDT. (CL)

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EPSDT

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A GUIDE FOR EDUCATIONAL PROGRAMS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration
Office of Education
Public Health Service

EC150682

EPSDT—A HOW-TO GUIDE FOR EDUCATIONAL PROGRAMS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE:

HEALTH CARE FINANCING ADMINISTRATION

OFFICE OF EDUCATION

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INTRODUCTION

In response to needs and issues in child health, the Department of Health, Education, and Welfare has developed a child health strategy designed to help communities meet the health needs of their medically underserved children, such as the Medicaid population. The Child Health Strategy's major objectives are the improvement of the health status of mothers, children, and adolescents through a well coordinated, highly effective, responsive system of health care delivery which combines the resources and experiences of Federal, State and local health agencies in a cooperative effort to reach mutually agreed upon results. (The Health Care Financing Administration (HCFA), the Public Health Service (PHS), and the Office of Education (OE) are the HEW agencies leading this portion of the Child Health Strategy.)

Consistent with the Child Health Strategy's goals is the intent of HEW, through a variety of programs, to assure provision of comprehensive, quality health care to children throughout their pediatric years. This entails giving attention to all aspects of health, including preventive health services, the care of medical emergencies and acute and chronic illnesses, and the establishment of a "medical home" environment for initiation of care, its coordination, evaluation, and interpretation. To fully provide for the wide range of health/education needs of a large number of children may require the skills of a broad team of professionals working collaboratively—physicians; psychologists; audiologists; social workers; nutritionists; physical, occupational, and speech therapists; nurses; nurse-practitioners, and regular and special educators. Effective communication of each team member's evaluation and participation in the ongoing plan of care for the individual child is required. Despite the widely-held belief that children of school age are an essentially healthy population, there is increasing evidence of the prevalence of health problems and health related conditions in the school age population which deserve critical attention. Education and health care providers and agencies can take more leadership and responsibility for planning, organizing, and implementing programs of health care to reduce the incidence of disease and improve the health status of school-age children.

It is believed that health care offered in schools can contribute significantly to the goal of the provision of comprehensive health services for the school age population.

The school setting can be an important means of improved identification of health problems, of increasing students' access to both curative and preventive health services, and of more appropriate use of health care resources through improved student understanding of their health problems. The schools may be important catalysts in developing linkages of school services through the family to public, private, and other community health and social services.

However, while not infeasible, there are obvious limitations in providing ongoing primary care in the school setting, since by definition primary care is outlined as continuous coverage, 24 hours a day, 7 days a week, of coordinated, comprehensive services convenient to patients (National Academy of Sciences and Institute of Medicine, July 1978).

It is further recognized that the delivery of appropriate health services to children supports educational goals of access for all children, excellence of educational services, and equity of opportunity.

EPSDT - A How-to Guide for Educational Programs is an outgrowth of these ideas--that there are important areas of common interest between the schools and health services. This guide was developed specifically to encourage and assist State education agencies (SEAs), local education agencies (LEAs), State and local health agencies, and others in becoming actively involved in their State's EPSDT program by using the school setting as one resource in a total system of health care wherever appropriate. Its timely development is a result of the need for States to develop a more effective relationship between public and private EPSDT providers and public schools. The establishment of such a relationship—health and education—increases advantages the eligible children could have in receiving comprehensive health care and services. The Guide is intended to reflect the necessary content and activities to be taken to achieve maximum coordination between health and education.

This Guide is designed primarily to encourage and assist State and local health and education staff responsible for health and support services in schools in becoming actively involved with their State's EPSDT program. However, parents, community groups, and others can make use of this Guide to more fully understand and participate in health care programs for eligible children. The use of this guide may vary from State to State depending on several factors: the EPSDT/school populations and their needs; the capabilities of the schools to participate in the EPSDT program; the availability of public and private health resources; the organizational placement of the EPSDT program and the organizational placement of the school health program; the philosophy of the SEA and LEA; and the State's general commitment to its needy population. These variables should be considered in determining the feasibility and the extent in which EPSDT services can be provided in school settings. Regional HCFA, OE, and PHS staff may also use this guide to provide technical assistance to States and major school districts interested in developing demonstration models for providing EPSDT outreach, case management, and where feasible and appropriate, service delivery.

In a national test of the potential rules of schools in increasing and improving EPSDT services to Medically eligible children, an experimental program is being initiated in the 1979-80 school term. The identification of ten (10) State education agencies to take part in this test (one in each HEW Region) is projected for this first year of the experiment, as are other initial action steps.

The Organization of this Guide

This How-to-Guide for Educational Programs is divided into four chapters, each of which concentrates on major components of the EPSDT program and describes what should be known and be done to utilize the resources available through the program to the fullest extent. The first chapter, The EPSDT Program, answers such questions as: what is EPSDT?; how does it work?; why should schools be interested in participating in EPSDT?; who benefits from its services?; what are the existing relationships among Medicaid, public and private health providers, and education agencies?; and what are the potential relationships?

Next, Chapter Two, School Roles in EPSDT, describes and defines the different services that may be available to EPSDT children in the general areas of "outreach," "case management," and "service delivery."

The third chapter, How-to Do-It, identifies the necessary steps to be taken by and for SEAs and LEAs in preparation for participating in the EPSDT program.

The fourth and final chapter is Existing Models. It provides annotated descriptions of several examples of effective relationships between EPSDT programs and public schools. Appendices have also been included which contain directories of the following resources:

1) EPSDT Regional Coordinators
2) EPSDT State Coordinators
3) OE Regional Office Program Coordinators
4) Chief State School Officers
5) PHS Regional Program Consultants, MCH/CC
6) State MCH/CC Directors

These lists are provided in order to enable users of this Guide to identify, by name, the types of individuals referenced in the "contact" steps described in the How-to-Do-It chapter. Guide users should be able to call upon these people for assistance in pursuing the goal of school/EPSDT program integration.

The Appendices also include regulatory information on linking with, and being reimbursed, the EPSDT program.

The Context of the Guide

The initial purposes of this guide, as stated, are to acquaint users with what can be done, how to begin, and where to look for assistance, and to illustrate some examples of those programs which have been successful. The guide does not pretend to provide all of the answers. Each state and local area has its own idyosyncratic health and educational systems which must be understood and used, in order for actions to be taken to improve school and health collaboration.

This guide reflects one of the many activities currently underway to improve interagency collaboration in service delivery to children. The participating federal agencies recognize the need to design and develop service delivery strategies at all levels which maximize the use of existing resources and diminish fragmented approaches to the child. The authors recognize there is one "whole child"; not an educational, health or social service child. This guide deals with one piece of the service delivery puzzle which we must all help to put together if children and youth are to fully receive the benefits of our society.

We strongly urge interested readers to consider the collaborative service delivery effort as a major activity and to undertake broad approaches at the State and local levels to expand this initiative to include other activities such as mental health, corrections, preventive services, etc. Personnel of the federal offices named herein will be glad to provide interested readers with contacts and available literature for further initiatives.

Preparation of this Guide

This *Guide* was developed jointly by three components of HEW most concerned with the child health: the Health Care Financing Administration, the Office of Education, and the Public Health Service.

CHAPTER I. THE EPSDT PROGRAM

A. The Schools and Medicaid Eligible Children

The health of children is a major concern to parents, health providers and educators. It is generally accepted that the early identification, diagnosis and treatment of health problems can improve the health of children and their performance in school, and, for handicapped children or others with serious health conditions, can diminish the probability of the development of secondary handicapping conditions. Studies such as the National Nutrition Survey, the National Center for Health Statistics study, those conducted by the Office of Child Health, and others show that Medicaid eligible children have more health impairments than the average child. For example, the Medicaid children:

- Suffer 23% more hearing impairment
- do not grow as tall as other children
- are more likely to have low hemoglobin values during their years of growth
- Suffer a higher incidence of impetigo, gastrointestinal diseases, parasitic diseases, and urinary tract infections, and in addition, those in urban areas are more often the victims of lead paint poisoning, and insect and rodent bites.

These children are likely to have twice as many hosptial stays, more days in bed both in the hospital and at home, and more days lost from school than the average child, as well as more impairment from chronic disease.

Statistical reports from State Medicaid agencies show that among the children assessed through the program, 45 percent require follow-up referrals for an average of over two conditions:

- 50% are found to be inadequately immunized
- 25% are found to have severe dental problems
- 12% have low hemoglobin
- 10% have vision problems
- 9% in urban areas have elevated blood lead levels
- 8% suffer from upper-respiratory problems
- 7% suffer from genitourinary infections
- 3% have hearing problems

Some children with previously undetected conditions, such as cancer, epilepsy, and congenital defects have been identified through the EPSDT program.

Many handicapped children identified by Child Find, State Crippled Children Services, Head Start, and other early identification programs may also be Medicaid eligible. The State Medicaid program may thus be one resource for diagnostic evaluations, treatment, and other related services required as part of the comprehensive system of resources for handicapped children.

B. Considerations Regarding School Health

1. Assumptions Underlying this Guide

- Children receiving appropriate health services are more likely to succeed in school and to achieve full participation in our society.
- Because of the unique continuity of contact with children, youth and their parents, the schools can offer an important focal point from which to refer children and youth to EPSDT services.
- The development of relationships with Medicaid and other health providers offers schools a unique opportunity to improve the quality of their health programs and assure a full range of appropriate health services to handicapped children.
- The use of the schools to increase and improve services to EPSDT recipients is intended to: reduce duplication of services; reduce long term health costs to the community; fill service gaps for children presently not receiving care; lead to improved educational outcomes; reduce interruptions in the educational process; extend the range of services to handicapped children; and reduce school associated costs due to children's illnesses and absences.

2. School Health Goals

School health services have as their goal the optimum growth and development of all children of school age. This is obviously a goal shared by many others in the health field. However, the unique contribution of school health services in the attainment of this goal is through their relationship to the needs of the school age child to achieve specific developmental tasks in preparation for future responsibilities as workers, parents, and citizens.

There are three basic areas of concern of school health:

- A school environment which protects students from physical, mental, and social conditions which would be hazardous to their health.
- The need for all students to reach an optimal level of health in order to function most effectively in the educational environment.
- A health education program which prepares students with the necessary knowledge and skills to protect and maintain their own health and the health of others in society.

These basic concerns are addressed in a variety of ways by school health systems. Whether operated by local or State departments of health, boards of education, school districts or by individual schools, school health provides the opportunity to select and provide for a system of relevant activities which result in an improved health status of the school population.

3. Health Needs of the School-Aged Child

The list of health problems among children is clearly sufficient to evoke concern among parents, educators and those involved in school health services as well. School health must be responsive to such problems as alcohol abuse; drug abuse; venereal disease; unwanted pregnancies; low levels of immunization for measles, rubella, polio, diphtheria; physical handicaps; mental retardation; learning problems; behavioral problems; traffic accidents; home accidents; shop accidents; suicide; homicide; fires; dental caries, loss, deformities; food abuse; anemia; malnutrition; child abuse and neglect; sexual abuse; uncorrected speech problems; undetected hypertension; vision problems; health and emotional problems related to physicial disabilities.

C. The EPSDT Program

1 Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally sponsored Medicaid program administered by each State, in which Medicaid eligible families may voluntarily participate. In some States, the health department manages the program, in some States the welfare department manages it, and in a few States, a special commission is responsible for the program. The program is intended to provide a comprehensive range of health care services to children of Medicaid eligible familes.

Eligibility is provided to all AFDC (Aid to Familes with Dependent Children) and AFDC foster care families, SSI children and, according to State option, to "medically needy" families, children in intact families meeting State income standards.

Each of the features of the program's name combine to make the EPSDT program unique:

__Early__: assessing a child's health as soon as possible, either in the child's life or when Medicaid eligibility has been established, so that potential diseases and abnormalities can be detected in their preliminary stages, when they are most effectively treated.

Periodic: also assessing a child's health at key points in the child's life, to assure healthy development.

Screening: the use of quick and simple tests and procedures to determine if children being examined may have a condition warranting closer medical/ dental attention.

Diagnosis: determination of the nature and cause of conditions requiring attention, by synthesizing findings of the health history, physical examination, and appropriate diagnostic tests and procedures.

Treatment: the provision of services needed to control or correct the diagnosed conditions.

Historically, the intent of the EPSDT program has remained consistent. The value of preventive health care, both in human terms and on a cost-effective basis, has long been established. Preventive health is especially important for children, as illnesses or handicaps not treated in childhood can easily become barriers to the individual's achieving their full potential in society. And for children who are receiving publicly funded health care, the cost avoidance benefits of treating illnesses now and eliminating the need for later expenditures (perhaps even in terms of a lifetime of such dependency) must not be overlooked.

2. State EPSDT Requirements

Federal regulations require that as a minimum (which States should be encouraged to exceed), States provide an array of services or conduct a series of activities regarding EPSDT, described below.

Screening examinations consisting of:

- health and developmental history
- unclothed physical examination
- immunization appropriate for age and health history
- nutritional status assessment
- vision testing
- hearing testing
- laboratory procedures appropriate for age and population groups

- direct referral to a dentist for diagnosis and treatment (for those over three years of age)
- developmental assessment (effective 1/1/81)

Diagnosis and treatment services consisting of:

- services as appropriate for medical ailments or conditions
- dental care needed for relief of pain and infections, and for restoration of teeth
- preventive health care, i.e. immunizations, etc.
- treatment for defects in vision and hearing, including eyeglasses and hearing aids.

Support services consisting of:

- arranging for and scheduling appointments
- transportation to and from services or appointments

Operational activities consisting of:

- developing and utilizing the capability of informing eligible families of available services, on a timely basis
- providing for screening, diagnosis, and treatment within 120 days of the date a family requests services
- seeking out and developing agreements with providers to serve the required services.

3. How the EPSDT Program Works

EPSDT is a State-administered program, and there is no single federally mandated procedure or system through which the program should be conducted. States have placed the program in their welfare departments, health departments, or separate commissions. Some States use private providers for service delivery, while others have stressed the use of county health departments. There simply is no typical or uniform organizational model of an EPSDT program because of this wide variation in State and local needs and resources.

EPSDT is a Medicaid program under Title XIX of the Social Security Act, and the Medicaid agency is responsible for assuring that the EPSDT program is operated effectively. To do this, the Medicaid agency can contract with other public or private agencies for help in certain tasks, as discussed below.

HEW is encouraging States to make maximum use of all types of providers: regulations prohibit restrictions on the type of practitioners participating in the EPSDT program.

However, experience with the program and implementation of federal guidelines have resulted in the emergence of a general approach or sequence of events in the functioning of EPSDT. A simplified diagram of these events is shown on the following page, and each step is briefly described below.

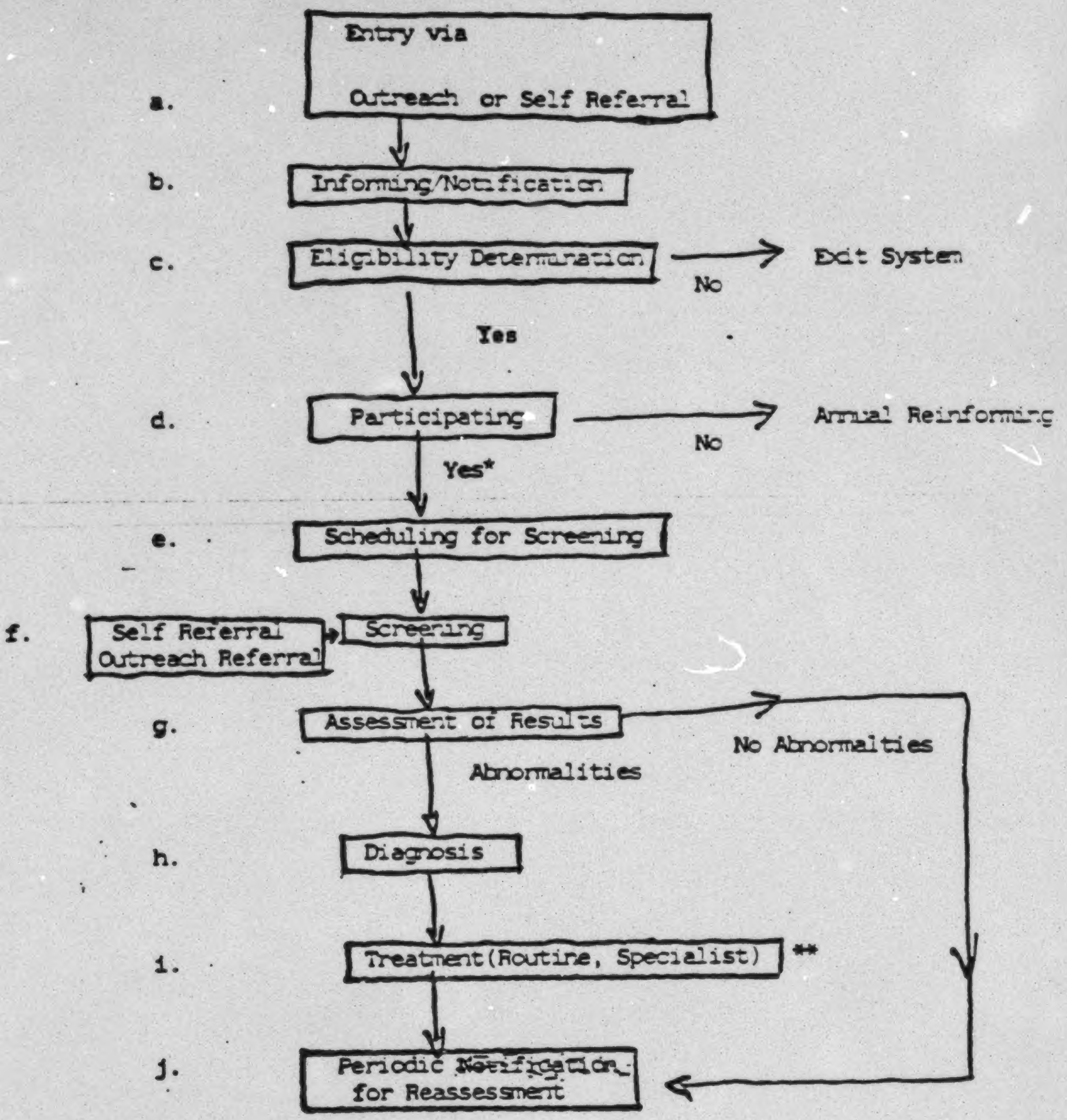
It should be noted that the system has two "tracks"--some activities relate to recipient concerns, and some relate to agency responsibilities. Both are reflected in the discussion below.

a. Outreach

Outreach is the continuous activity (often relying on both Medicaid agency staff and staff from other public and private organizations,) of identifying and contacting children and families who may be eligible for EPSDT.

In the context of school/EPSDT cooperation, outreach involves the schools themselves in identifying and contacting children and families. The major advantage that schools have in this activity is their daily physical access to the population, which other programs (i.e., AFDC) cannot provide. Outreaching a finite population should be accomplished more readily and effectively than would be a dispersed categorical population.

EPSDT FLOW OF EVENTS


Entry via
a.
Outreach or Self Referral
b.
Informing/Notification
c.
Eligibility Determination
No
Exit System
Yes
d.
Participating
No
Annual Reinforming
Yes*
e.
Scheduling for Screening
f.
Self Referral
Outreach Referral
Screening
g.
Assessment of Results
No Abnormalties
Abnormalities
h.
Diagnosis
i.
Treatment(Routine, Specialist)
**
j.
Periodic ~~Notification~~
for Reassessment

*If family/child participates but uses own provider, they should automatically accomplish the next few steps, and should come into the system again at the last step, to be periodically renotified for the next assessment.

**Should be reinforced by a continuing care relationship, after initial treatment is completed.

In States relying heavily on private providers (rather than on county health departments) to provide necessary services, Medicaid agency staff must continue to seek out these providers and recruit them for participation in the program. Otherwise, turnover and attrition would result in inadequate provider enrollment.

b. Informing/Notification

Using a variety of techniques and materials, the EPSDT agency must explain the value of preventive health services to eligible or potentially eligible families and children, and encourage them to participate.

There are two levels of informing which should be conducted. One, public education on a large scale in areas where many eligible families are expected to be found, is often tied to the outreach function. The second type of informing is more formal, and is conducted on an individual family basis. EPSDT regulations mandate both a face-to-face discussion provided by the Medicaid agency staff or other public agency employees (i.e., AFDC or Title XX staff), and a written brochure explaining the purpose and services of the EPSDT program.

On an annual basis, the Medicaid agency must inform all know eligibles who are not participating in EPSDT of the availability of the program and its services.

c. Eligibility Determination

The eligibility of a family for Medicaid, which includes EPSDT services, must be determined by the State Medicaid agency. Families eligible for AFDC, AFDC-Foster Care, and Supplemental Security Income (SSI) are eligile, as are foster care children and the "medically needy" in many States. (This latter group is often comprised of the "working poor," whose income is too high for AFDC eligibility but too low to afford complete medical care.)

If a family is determined to be eligible, they must decide whether or not to participate in this voluntary program, i.e., receive EPSDT services. If a family is not found eligible, then the EPSDT program usually will have no further contact with them, unless the family becomes eligible at a later date.

d. Participation

Once the eligibility of a family has been established, the family must decide whether they wish to participate in EPSDT. Medicaid agency staff should have made clear what medical and support services are available. Scheduling assistance and transportation are services which all States must provide, but other services such as babysitting are also helpful in getting families to participate.

Eligible families which do not choose to participate do not proceed further into the EPSDT system. Instead, they are only reminded annually of the existence and benefits of the EPSDT program. Families which do participate proceed to the next step, of having screening arrangements made.

e. Schedule for Screening

In order to assure that the family has access to medical care if the family desires, the Medicaid agency staff will set up a screening for the child, or the family may make an appointment individually. In many cases, families may simply present themselves at a provider's office and receive a screening without prior notice to Medicaid agency staff. In any event, the family must be given a choice of providers for the screening.

The Medicaid agency must assure that there are adequate numbers of providers participating in the program to meet the screening and service needs of EPSDT participants in a timely way. Many States have adequate physician participation, but some States also report that participation from dentists and specialists across the State, and from providers of all types in rural areas, is difficult to assure.

f. Screening

In accordance with State standards, the provider must conduct an examination consisting of at least those federally required tests and assessments listed on pages 16-17.

As stated above, the Medicaid agency must make support services (i.e., at least help with transportation and scheduling) available so that the family can keep the appointment for screening. These appointments are important: they are the way for many children and families to enter the EPSDT system.

The tests and procedures used in screening are intended to be quick, inexpensive, and easy to administer. They are not necessarily intended to provide conclusive proof of a problem or abnormality, only the indication that one may exist.

g. Assessment of Results

Results of the screening tests and procedures should be assessed and noted in the child's health record as soon as they are available. In those cases where no abnormalities are indicated, the only necessary action for the State Medicaid agency to take is to notify the child or family when the next periodic screening examination is due.

Cases where problems or abnormalities are indicated should be referred for diagnosis. If the child is receiving care from a continuing care provider, then screening, diagnosis, and treatment can be provided by that same practitioner.

h. Diagnosis

The purpose of diagnosis is to determine the nature, cause, and extent of the problem or abnormality found by the screening examination. Diagnosis should culminate with the development of a plan for treatment when it is necessary and appropriate.

The EPSDT program requires that all children over 3 be referred to a dentist automatically, just as they are referred to medical practitioners. The dentist will perform screening, diagnosis, and treatment as appropriate. In the past, dental screening and diagnosis had been performed as a portion of the medical procedure, not as a separate activity parallel to it.

i. Treatment

Treatment must be provided according to diagnostic results, within the scope of the State's Medicaid Plan. The treatment can cover a very broad range of activities, from a one-time office visit through a lengthy and complex course of treatment or counseling.

Treatment may be provided by a broad range of providers. Some may have expertise in performing a portion of treatment services needed (i.e., opthalmologists providing vision services), while some may provide all of the necessary services (with referrals to appropriate specialists as needed). This latter type are termed "continuing care" providers, because once they see the child for the first time under EPSDT and can initiate a relationship with the child or family, they will be in a position to respond to all of the child's health care needs on a continuing basis. This practice helps further the EPSDT goal of getting as many children and families into regular medical care as possible.

j. Periodic Renotification

At intervals set by each State, eligible children should be re-screened in order for the concept behind the EPSDT program, preventive health, to be effective. Generally, these intervals are relatively short in the first few years of life—many states call for 6-8 examinations in the first two years of life.

Progressively, as the child gets older, there are fewer recommended examinations, perhaps at three years intervals, until age 21.

The periodic notification process is designed to inform children and families about the screening due, to remind them of the benefits of participating in EPSDT, and to back this up with an offer of necessary support services.

4. Reimbursement Under EPSDT

The Health Care Financing Administration of HEW, the agency which is responsible for the EPSDT program on the federal level, reimburses States for costs they incur in conducting several activities, including:

- Screening, diagnosis, and treatment of eligible children, at a rate of 50-78%, depending on a State's per capital income

- Outreach and follow-up costs at 75%
- Other Administrative costs at 50%
- Transportation costs at 50-78% if part of medical services under the State's Medicaid plan, otherwise at 50% as an administrative cost.

Education agencies which seek to become EPSDT providers may be eligible to be reimbursed for expenditures under any of the above categories. Reimbursement conditions and procedures vary from State to State, so education agencies should ascertain the necessary information from their State's EPSDT program.

Several of the education agencies already participating in the EPSDT program have felt that reimbursement has helped their program. One view is that significantly greater numbers of children can be served, and more services provided, for the same costs to the education agency, because of the reimbursement's "multiplier effect". In other instances, where budgets have been cut, the original level of services can be maintained but at reduced expenditures, through that same multiplier effect.

An Appendix to this guide contains HCFA Action Transmittal AT-79-101, which provides information on how to seek reimbursement for expenditures through Medicaid.

CHAPTER II. SCHOOL ROLES IN EPSDT

A. Introduction

Because of the unique nature of their contact with children, youth and parents, schools (through health personnel) offer an important focal point from which to identify children with problems, to increase student's access to both preventive and curative health services, and to assure appropriate use of health care resources. The development of linkages through the family to public, private, and other community health and social services is needed in order to integrate existing treatment and prevention programs with those services provided in the schools. Coordination of all services--outreach activities, screening programs, treatment, and follow-up services—should be emphasized between school health and other health care providers, and social agencies in the community, to avoid duplicating efforts, increasing costs of services and adding further stress to the child and family.

The EPSDT program is not a new one -- it began in 1967 legislation -- but schools have not played a major participating role in it. In undertaking this joint activity

the EPSDT program, then, there are several important things to be learned by both education agencies and the EPSDT agency. This chapter concerns the three major roles that schools can play in the EPSDT program, and provides information about each: outreach, case management, and service delivery.

B. Outreach

The purpose of outreach is to both inform potentially eligible families and children about EPSDT, and to begin recruiting them for the program.

The public school system in this country is a unique institution, in that it is probably the only universal point of contact between the child and family and large scale governmental service delivery organizations. Although there is not always full agreement on how best to utilize this contact, the health of children has been recognized as important by both educators and health professionals, and progress in school health services has been made.

One of the barriers to more active participation by schools in the EPSDT program has been the need to preserve confidentiality of recipients: to publicly single out some children for a public health program in which others cannot participate violates the concept of confidentiality. Medicaid status is not public information: it is a confidential matter between the family and the Medicaid agency, and is to be divulged to others only upon written authorization of the family or for certain administrative activities between agencies. Chapters 3 and 4 discuss potential ways to avoid this barrier, and an Appendix to this guide contains an Action Transmittal with administrative guidelines regarding confidentiality.

In providing outreach activities, schools have the opportunity to generally inform the school population on the importance of preventive health, and also contact eligible families to work with and encourage them on a more detailed basis. Such outreach activities should be provided, however, only after an analysis of the existing community outreach program has defined the most appropriate role of the school in this activity. An outline of a typical outreach strategy begins with:

- an assessment of the existing community outreach activities
- informing families about EPSDT
  - what it is
  - advantages of early detection and treatment
  - how to participate in the program
  - what EPSDT services can be obtained
  - what support services are available

This strategy must actively encourage and support participation by eligible families, by conducting the following activities to overcome potential barriers for the family:

- helping to select a provider
- assisting in arranging for appointments

— arranging for support services (transportation, child care)

— provide ongoing counseling to answer questions and reduce fear or confusion.

In a school setting, there are several specific kinds of outreach activities which can be conducted:

- personal contact with the child and family by school staff who are knowledgeable in the EPSDT program.
- personal letters to the child and family from school staff who are knowledgeable in EPSDT.
- individual parents or parent groups who are interested in the program and will work to identify, locate, and enroll other parents.
- development and dissemination of posters, booklets, and related materials which utilize culturally relevant concepts and terms.
- health fairs which focus on child health, and which stress preventive health and EPSDT.

The costs of outreach activities are eligible for reimbursement at the 75% level, as long as necessary interagency agreements exist which specify the objectives, responsibilities, and activities of the relationship. (See Appendix for copy of relevant Action Transmittal.)

C. Case Management

The purpose of case management is to organize in one place, or one system, information on all of the diverse health activities which are conducted for a child. Often screening, diagnosis, and treatment activities can not all be conducted in one time or place, so case management is intended to be a gathering and synthesizing of information from several scattered sources. This process is crucial if a child is to be assured of being tracked through the complex world of health care services and providers, and of ultimately receiving the necessary services on a timely basis.

Some schools may be well suited to assisting in the case management role, which ultimately is a responsibility of the State Medicaid agency, according to current regulations. Schools currently perform administrative tasks which are equivalent to case management in EPSDT — tracking progress of students from one grade to the next, gathering and interpreting results of standardized test scores, referring children (either directly, or following special diagnostic testing) to special types of education programs according to the needs of each child, designing remedial programs. This capability may be transferred to supporting case management in many ways, such as:

- assisting families in the choice of providers, especially those convenient to the school
- using the school as a resource in scheduling appointments and in providing transportation
- passing records between the EPSDT program and the family to verify what activities have taken place, to maintain records, to assure a timely flow of information
- follow-up with families to assure that children have received the diagnosis and treatment they require, according to screening result
- helping families maintain contact with providers.

As discussed earlier in Section B Outreach, it is equally important that schools participate in case management after: (1) an assessment of the existing case management activities in the community, and (2) the most appropriate role for schools in improving case management has been defined.

D. Service Delivery

At Federal, State, and local levels, mutual interest in providing EPSDT services in the schools has been expressed by both educators and health care professionals. There are a variety of ways in which schools can either become providers of some or all of the required EPSDT services, or can otherwise assist in the provision of EPSDT services. Some of these roles such as outreach and case management have been discussed previously. The most complex and difficult role for schools to play is as providers of services themselves.

The schools' role of EPSDT provider can have so many alternative forms that this role should be viewed as consisting of a cluster of potential activities rather than as a single rigid series of clearly defined health care tasks. It is not possible to cite all of the potential forms of service delivery for schools in this manual, but it is useful, for educators seeking to bring EPSDT into the schools, to consider some of the service delivery models described in this manual. Three such models are provided in Chapter 4.

There is no "best" or "correct" way for schools to relate to EPSDT, since the populations, political will, resources, and other factors surrounding schools will vary greatly between communities. For example, schools in affluent areas with no Medicaid eligible population would not benefit from bringing EPSDT into the schools, or areas where resources are scarce may only be able to provide limited or partial services.

The models in Chapter 4 reflect three basic roles of service delivery for schools. In one model, school nurses can be used to provide screening services for children, and those cases found to have abnormalties can be refered to other providers for diagnosis and treatment. In the second model, schools can contract with private physicians for them to provide screening, diagnosis, and/or treatment services. Third, the school can be used as a site for the provision of public health services.

Chapter III. HOW TO DO IT

Introduction

There are a number of procedural steps which schools must complete in order to become involved in providing EPSDT. Just as there is no one "best" or "correct" approach to service delivery, there is also no one best or correct way for schools to prepare to become an integral part of the provision of services. This chapter presents a generic approach which schools could follow in seeking to become providers.

State-Level Program Orientation and Coordination

As should be clear from reading the preceding chapters in this *guide*, the EPSDT program is a complex one, and educators seeking to become involved with it for the first time should receive at least a basic orientation in EPSDT. Variations in the nature of EPSDT between states make it impossible for this *Guide* to present a single *detailed* orientation document: educators will have to secure their orientation from EPSDT staff in their own States. The best single source of information about EPSDT is each State's *Medicaid Plan*, since EPSDT is a Medicaid program. This plan will describe the services provided under EPSDT, and the way in which these services are to be delivered.

Additionally, since EPSDT is concerned with child health, equally as important is a similar orientation about the responsibilities for and the provision of child health services in a State. The major sources of information for these services are the *Maternal and Child Health* and *Crippled Children's Services State Plans*. These are especially important since there are very few settings within which health services for only EPSDT recipients will be provided. Rather, most settings will provide services not only to the child eligible for Medicaid but for other children as well.

Appendices to this guide list the names and addresses of the EPSDT Coordinator and the Maternal and Child Health/Crippled Children's program Directors for each State. There is a sample letter at the end of this chapter which may be helpful to you in composing a letter of your own, requesting a copy of the State Medicaid Plan and MCH/CCS Plans. The end of this Chapter also includes a description of what information may be found in in these plans.

Educators should be aware that not all of the necessary child health services are provided in a single setting, or by the same provider. Often times, children must receive services, especially those of a complicated diagnostic and treatment nature, away from the major primary care setting, which may not even be located geographically in the local education jurisdiction. It thus is necessary to have knowledge of the variety of resources that are available to provide full and comprehensive health care.

An important first procedural step is to have joint meetings which include the State EPSDT Coordinator, the State Maternal and Child Health and Crippled Children's Directors, and key staff members of the State Education Agency. These meetings should be designed with a view toward exploring the possibilities of utilizing the school settings to provide health services to Medicaid recipients.

Discussions about the resources necessary to provide health services, standards of care, coordination and integration among community resources both public and private, outreach activities, health care management, patient tracking systems, to name a few, are necessary topics during these meetings.

Meetings which include representatives of these three State Agencies should be held with their counterpart representatives of the LEA area or areas being considered. An Appendix to this guide (HCFA Action Transmittals AT-78-2 and AT-78-46) describes the interagency agreements which must be developed between the PHS programs and the State Medicaid Agency, especially in relation to the EPSDT program. Schools should be able to make use of these documents in developing their own interagency agreements.

Similar discussions as occurred in the State level meetings but at a more detailed level pertinent to the local areas should be held among the participants with the intent of finalizing the selection of the participating areas/schools.

State agency staff should provide the technical assistance and professional consultation to the local area(s) during the implementation of the program(s).

Local-Level Program Orientation and Coordination

An LEA representative should identify the EPSDT agency in the area covered by their schools, by contacting their local public welfare or health departments. LEA staff should meet with local EPSDT staff and child health representatives in order to complete the mutual orientation process and to begin program coordination efforts.

Topics which should be covered at such a meeting (or more realistically, a series of meetings) include:

- the number of Medicaid (i.e., EPSDT)-eligible children in the schools involved
- how to determine/verify Medicaid eligibility
- procedural safeguards regarding confidentiality which must be employed when exchanging information between agencies regarding individuals and families. A document regarding confidentiality is attached as an Appendix to this manual.

- existing health screening practices used by schools
- any apparent duplication of effort in school or health program screenings, perhaps determined by comparing rosters or other forms prepared by each agency or by other providers
- potential barriers, if any, to more coordinated screening efforts (confidentiality, reimbursement levels)
- local action steps necessary to integrate screening programs and introduce EPSDT into the schools.
- any present system used to refer EPSDT eligible children to diagnostic and treatment facilities, and methods used for following up on referrals
- policies, proposals, and standards of care necessary for the provision of child health services.
- existence and type of system used to track children through EPSDT, and other health systems, and procedures for education agencies to obtain this information

The final stage of this local level program orientation and coordination is the development and adoption of any necessary interagency agreements. These should set forth the education, EPSDT and child health goals and the measurable objectives to be achieved as a result of the collaborative effort, the responsibilities and activities to be undertaken by each party, and the resources each is prepared to commit to the effort.

Establishment of Steering Committee

A local steering committee should be established which may include representatives from such organizations as the LEA and/or school jurisdiction, the public health sector, Medicaid/EPSDT, and other appropriate representatives from the health sector such as private practitioners, community health centers, etc.

Establish Contact with Local EPSDT Service Providers

The local EPSDT agency should supply the steering committee with a list of individual practitioners, agencies, and health programs providing EPSDT services. According to where each State places its emphasis, these providers may be mostly public agencies (i.e., county health department offices), mostly private providers (i.e., individual doctors and dentists, or a mixture of these. EPSDT regulations require that recipients be given their free choice of providers, so school staff should be aware that there may be a broad group of providers to work with.

Although contact with providers is generally a Medicaid responsibility, it would probably help this collaborative effort (in the eyes of providers) if the steering committee were to contact the providers, not the Medicaid agency.

This contact should include:

- assurance of private practitioner participation on the Steering Committee
- description of education agency's role, interest, and responsibility in the school/EPSDT coordination effort
- description of the public health agency's role, interest, and responsibility in the school/EPSDT coordination effort

- description of support services (i.e., transportation, physical therapy) provided by the education agency, and identification of any eligibility criteria attached to those services
- how schools and local public health resources can help reduce the number of broken appointments by providing better support services or locations for service delivery
- procedures for exchanging information on screening, diagnosis, and treatment results
- description of how confidentiality will be assured
- a plan for mutual site visits

Synthesis of First Steps/Begin Development of Service Plan

The local education agency, in coordination with its steering committee, should begin developing specific plans for coordinating EPSDT and education programs. To form the basic components of this plan, the education agency should:

- review information received from State and local EPSDT/Medicaid staffs, such as the State Medicaid Plan, and from the State and local child health programs, including handicapped children's programs
- compare the EPSDT screening package with requirements of other screening programs the schools are involved with, in an effort to have uniform health screening standards
- adopt EPSDT provider performance standards, secured from community health programs

Focusing on Outreach

Outreach, as discussed earlier in this manual, is one of the EPSDT activities in which schools can be most effective. It is also one area in which schools can most readily become involved, so it will be highlighted in this how-to-do-it chapter.

Planning for Outreach

The education agency may establish procedures for conducting outreach activities. Steps in the development of outreach activities are:

- select the organizational component and the individuals within the education agency which will have responsibility for conducting outreach
- determine current outreach methods used by EPSDT, education, and public health programs seeking to enlist family participation
- identify staff resources currently used to do outreach for other programs (i.e., social workers, psychologists, special educators, community relations workers)
- design an outreach information gathering strategy appropriate to local conditions, to determine children's eligibility for EPSDT, and to identify those already receiving EPSDT screening.
- Secure materials for use in the outreach processs, informing families with eligible children of the services available and of confidentiality guarantees provided during participation. (These materials are available from the Medicaid agency.)
- conduct a staff training program for those who will be conducting outreach activities, focusing on:
  - — how to explain EPSDT to families
  - — advantages of early detection and prevention of disease

— telling families how they may participate in EPSDT

— securing needed family information for use in determining eligibility.

When the plan has been prepared, the staff has been trained, and the necessary materials have been secured, outreach activities can be conducted.

Planning for Monitoring and Follow-Up

Because of their day-to-day physical contact with the children, and their experience with maintaining scholastic/testing records and with following students from grade to grade, the schools are in an excellent position for monitoring and following up under EPSDT. Schools should develop a plan for conducting this activity.

Such a plan should determine the extent to which health services are being provided, and the degree to which coordination of services between EPSDT and other programs is taking place.

It is important to know that there will be in some instances an existing care plan for the EPSDT recipient. Among these may be the Individualized Education Program (IEP) for those children receiving special education, the Individual Service Plan (ISP) for those under the Supplemental Security Income Disabled Children's Agencies, other care plans developed by health providers, such as physicians, the local health department, and private organizations providing services for the handicapped. A means by which one care plan, if at all possible, can be used as a principle vehicle for monitoring the provision of services, is a priority area for action.

Progress through the EPSDT program, as seen in any individualized care plan that has been developed, should be reviewed periodically with the family, based on the needs of the individual child, to assure that necessary diagnostic and treatment procedures have been completed.

The local steering committee should monitor overall activities of schools at the local level. The participating State agencies should mutually oversee activities across the State and provide necessary technical assistance and professional consultation. States should in turn report collaboratively to designated OE, HCFA, and PHS regional office and central office staffs.

SAMPLE LETTER TO STATE EPSDT COORDINATOR

EPSDT Coordinator
State Medicaid Agency (by name)
State Capitol City, State

Dear EPSDT Coordinator:

I am the (title) in/for ______________________________ (county/school system) in ___(City)___. During the course of our program year, we provide educational/related services to (Number) handicapped children. Of these, about (Number or Percent) are eligible for EPSDT services under the Medicaid plan. In preparing for these children to receive EPSDT services, our program needs some specific information about ___(State's)___ EPSDT plan. The facts we need include:

- Who is eligible (categories and income levels)?
- What tests and procedures are included in the screening package? What tests are optional?
- At what ages is a complete screening performed? Are follow-up or partial screenings performed at other times? What ages?
- What tests are included in the follow-up screenings?
- Who can perform screening services? Nurses? Pediatric nurse practioners? Physicians?

Will you please provide us with a copy of the state plan along with the name and phone numbers of an appropriate contact person who can respond to our additional informational needs as they arise.

Additionally, we would also appreciate receiving a copy of the screening form and a list of approved screening, diagnosis and treatment providers in our area.

After we, (staff at supply name), become familiar with the materials you provide us, we would like to convene a meeting between the EPSDT staff and ourselves for the purpose of exploring coordination of our respective services. Perhaps you could indicate who from your office might attend such a meeting and some possible dates when you send the requested materials.

respond to our request. We look forward to working collaboratively with the EPSDT program.

Sincerely,

(Name)
(Title) (LEA)

SAMPLE LETTER TO SCREENING PROVIDER

Dear (Provider's Title):

I am (Name, Educational title) for (Special Education Program/School) in/at (School System/Region). Our program provides educational/related services for handicapped children (ages 0-21 yrs.). As our program also provides screening, diagnosis, and treatment services for educational purposes, we are seeking your cooperation to coordinate referral provision.

Many of EPSDT children screened by yourself (your program) may also have handicapping conditions which will require specialized services. Notification from your office as to who these children are and the condition noted will allow us to anticipate their educational needs and prepare responsive programs.

It would save duplication of outreach/screening efforts, if when noting a particular child has a handicapping condition, a copy of the screening results could be sent to his/her home school. Additionally, if referral was necessary, we would like the name of the provider to whom you referred the child.

As you may already be aware, any information provided to us by yourself will be handled in a strict confidential manner, as mandated by P.L. 94-142.

In advance, thank you for your assistance. We look forward to hearing from you. Please do call us at (phone number) if you have any questions or require more information.

Sincerely,

Name
Title, Educational Unit

The Early and Periodic Screening, Diagnosis and Treatment program is a federal program designed to give states responsibility for providing a comprehensive range of health care including preventive health services to Medicaid-eligible children 0-21 years of age. Because EPSDT is primarily a state-administered program, each state defines and implements EPSDT according to its own resources and regulations -- within minimum federal standards.

Most states have a written document which is called the EPSDT* state "plan." Hopefully, you have already written to your state's EPSDT coordinator and requested the plan. Read through the plan carefully to get the following information.

ELIGIBILITY

Who is eligible for EPSDT in your state?

Federal law requires states to include all children from birth to 21 years who are members of families receiving Aid to Families with Dependent Children (AFDC). Some states, in addition to these children who are determined "medically needy" or medically "indigent." A few states offer screening services, at little or no cost, to children who are not eligible for Medicaid. After reading the state plan, you will have enough information to refer families, who may be eligible to the agency in your community responsible for administering EPSDT.

NOTIFICATION

Who is told about EPSDT?

Families eligible for, but not participating in, EPSDT are informed about the service at least once a year — in writing. This means that they receive a brochure in the mail or are given one during eligibility determination at the Welfare Office. You (the LEA) want to request some brochures from the local welfare office. These brochures will be helpful as you explain to parents of handicapped children who are also Medicaid eligible that there are additional services available to them through the EPSDT program.

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*Even the name "EPSDT" is not universal. In Illinois, Hawaii and Oregon, it is Medichek; in California, Child Health and Disability Prevention Program (CHDP); in New York, Child Health Assurance Program (CHAP).

SCREENING PACKAGES

What tests and procedures are included in your state's screening package?

Most states offer a "package" of screening tests that are commensurate with guidelines provided by local community health programs. Review the list of services offered to EPSDT eligible children to see if there are components duplicative of those conducted during educational screenings. Usually a child receiving his first EPSDT screen receives all tests. Children may be eligible for screening every year, every two years, or less often. To determine your state's frequency of screening services you will have to read its "periodicity" schedule.

HEALTH CARE PROVIDERS

A. Where are screening services available?

Typically, one of three models is used in most states:

1. Screening services are provided by public health departments with referral for diagnosis and treatment to private Medicaid providers.
2. Screening, diagnosis and treatment are provided by private physicians and dentists, hospitals, clinics and other authorized providers including some Local Education Agencies.
3. A combination of 1 and 2.

The state plan will indicate who is participating in the EPSDT program in your state. Your local welfare department or EPSDT agency has a current list of screening providers in your area.

B. Where are diagnosis and treatment services available?

Diagnosis and treatment are available from Medicaid providers. This includes private doctors, hospitals, clinic, dentists and, some health departments.

SUPPORT SERVICES (TRANSPORTATION, CHILD CARE, OUTREACH AND FOLLOW-UP)

A. What transportation services are available for the EPSDT program?

Methods of providing transportation vary widely from state to state and within states. Some typical arrangements include:

1. Reimbursement for mileage to persons using private autos.
2. Tokens provided by case workers which can be used on public transportation.
3. Contracts with agencies to provide transportation.

B. Which agency(ies) is/are responsible for outreach and follow-up under the state plan?

It may be the health, welfare or EPSDT agency or another group under contract. Education may be able to receive reimbursement for outreach or follow-up activities.

The three major functions and activities Education can perform in using EPSDT resources to deliver health services to Medicaid eligible children are outreach, arranging for screening and follow-up.

OUTREACH

- Explain EPSDT
- Identify Eligibility Status

ARRANGE FOR SCREENING

- Identify screening and continuing care providers
- Offer scheduling and support services to families

FOLLOW-UP

- Identify diagnosis and treatment providers if not obtaining care from continuous care providers
- Offer scheduling and support services to families
- Assure that efforts are made to secure needed care
- Assist in scheduling periodic screening appointments

Each of the preceding sections discusses one of these in detail. Read through them quickly to get the flow and then study them separately later. You will soon see how "doing your homework" at each step in the process makes the next step easier.

CHAPTER IV. EXISTING MODELS

A. Introduction

There are several examples of successful partnerships between local educational systems and EPSDT programs. They have occured in a variety of ways in several locations across the country, some dating back to the early years of EPSDT.

Although the number of examples provided in this manual is small, these examples have contributed significantly to an understanding of workable, practical approaches to building EPSDT-LEA relationships. This chapter will describe three basic models: They might be entitled "The School as Outreacher;" "The School as Screener," and "The School as Full-Range Provider." Each of these models address different roles for the schools, each serves a different purpose appropriate to local conditions, each entails different organizational, procedural, and funding considerations, and each places the school in a vital role of helping to assure quality health services for needy children.

The focus of this chapter will be on each of these different roles in turn, and existing models will be used to illustrate how each role can work.

B. "The School as Outreacher"

Under this model, the school acts basically as an outreach agent for the EPSDT program. As discussed earlier in this Guide, EPSDT outreach is a process of identifying eligible clients, informing them of services available, and recruiting them for participation in the program. This could be accomplished in conjunction with other outreach activities the school might be involved in, such as identifying children with potentially handicapping conditions as required under provisions of Public Law 94-142, and other activities.

The Philadelphia public school system provides a working example of this model. The school district there has entered into agreements with several hospital clinics and private physicians to provide screening to children in certain grades of the school program. Since the state Public School Health code requires physical examinations for all children in some grades, and the EPSDT screen satisfies the requirements of this code, the program directly benefits the schools as well as the EPSDT program and its client-children.

Since providers agree to diagnosis and treatment or referral for all Medicaid-eligible children whom they screen, the school's role has the effect of placing eligible children and their families in direct contact with sources of continuing medical care. The district carries out this role in two ways: In some parts of the city, eligible children are referred directly to clinics or private physicians for screening; elsewhere (where there are high concentrations of eligible children), providers perform screening services at the school.

In either case, the school does not act as the EPSDT fiscal agent: providers are directly reimbursed by the State Medicaid Agency. In the case of the in-school screenings, the providers screen all children, and absorb the costs associated with the screening of non-Medicaid eligible children. The schools are authorized to receive a 75% match of costs incurred by them in arranging and conducting the outreach activities.

For more information, conatact:

Director
Division of School Health Services
The School Districts of Philadelphia
Board of Education
21st Street S. of the Parkway
Philadelphia, Pa. 19103

C. "The School as Screener"

This model requires that schools serve under agreement with the appropriate state and local agency to provide screening for eligible children. They may also provide outreach as part of their EPSDT services, or this may be done by other agencies or providers. In order for the school to qualify as a certified provider of this service, they must employ qualified health personnel as specified in Federal and State regulations. In many cases, the screening is coordinated by school nurses, with supervision and participation by a qualified physician. In some situations, nurse practitioners may provide most or all of the screening. Paraprofessionals are often employed to assist in the screening process, as well.

The public school system in New Orleans currently operates a model of this type. In this example, an agreement between the State Departments of Education and Health and Human Resources allows the Department of Education to subcontract directly with local school boards for EPSDT screening. In the New Orleans example, school nurses work from prinouts of Medicaid eligible children to identify and recruit these children in the screening program.

If a medical problem is discovered during the screening process, the child in question is referred to a clinic or private physician for diagnosis and treatment. The school nurse then assumes follow-up responsibility, i.e., assists in scheduling appointments, works with the child and family to facilitate appointment keeping, assures that a report is sent to the school, and coordinates arrangements for such additional medical encounters as may be necessary.

This service is provided only to Medicaid-eligible children, and the LEA is directly reimbursed by the State Department of Education, which bills the Medicaid agency. Clinics or private physicians who provide diagnosis and treatment also bill the State Medicaid agency. The school may also be eligible for a 50% match of any administrative costs incurred in relation to the screening program.

Additional information about the New Orleans program is available from:

Supervisor of School Nurses
Department of Medical and Health Services
New Orleans Public Schools
New Orleans, La. 70112

A program which is similar in concept, but which focuses upon school-based health and developmental screening for pre-school children, was passed by the 1977 Minnesota legislature and is currently being implemented in the state. Part of this implementation involves development of agreements between the Departments of Health, Department of Public Welfare, and Department of Education to enable schools to receive Title XIX reimbursement for screening Medicaid eligible children. Additional information can be obtained from:

Coordinator
Preschool Screening Program
Minnesota State Department of Education
Capitol Square, 550 Cedar St.
St. Paul, MN. 55101

D. "The School as Full-Range Provider"

As in the case of the screening model, schools who provide the full range of EPSDT services must operate their program under the terms of an agreement with the appropriate state and/or local agency. Under this model, the school must be in a position to provide medical diagnostic and treatment as defined in an earlier section of this Guide, in addition to screening services. These services must meet all applicable Federal and State standards, and must be under the direct authority or control of the school district, i.e., the school must be the accountable agency with respect to direct provision of EPSDT services for its Medicaid-eligible population. In order to qualify, the school may either directly employ the necessary medical and allied professional personnel, or may assure the availability of certain services through contracts or other types of agreements with medical clinics, laboratories, or private physicians.

In many applications of this model, the key medical person will be a qualified Nurse Practitioner, a person trained to perform physician examinations, to diagnosis and treat common illnesses, and to serve as case manager for children whose medical problems require referral and follow-up.

A program of this type is currently being operated by the Hartford public schools. Under the terms of an agreement with the State EPSDT agency and with assistance from a University-based Health Center, schools provide a full range of primary medical and dental services to Medicaid-eligible children.

The program is located in a "medically underserved" urban area having a high concentration of eligible families and actually functions as the principal primary medical care facility for children of that population. Most of the services (including primary ambulatory medical care as well as outreach, periodic screening, case management, and medical follow-up) are provided by school-employed medical and ancilliary personnel operating out of the district's Health Services Unit. (A suburban off-shoot of the program offers screening alone, on the assumption that most children have access to their own physician.)

In the case of the Hartford program, the city administrative office serves as the fiscal agent who bills the State EPSDT agency and reimburses the school at a rate of 90% of the Medicaid monies it generates, retaining 10% of that amount for administrative costs. Additional revenues, including school health funds, private foundation monies, and financing made available from new state legislation (which resulted, in part, from the success of the Hartford project) are added to the fiscal base of the district Health Services Unit to the extent that the program is essentially self-financed. Contact:

Coordinator
Guidance, Health and Psychological Services
Hartford Public Schools
Hartford, CN

E. Summary

Each of these models of school-based EPSDT services offer certain benefits and present certain problems for the implementing school. A problem common to all of the models is the matter of confidentiality of information which identifies Medicaid-eligible children. This problem can be overcome in part through interagency agreements which authorize the school's status as an EPSDT provider, and partly through effective outreach strategies, insofar as the eligible family's right to privacy is not violated.

In the case of the screening and the full EPSDT service models, start-up costs pose a significant barrier; since the EPSDT program is of a reimbursement type, schools may have difficulty in acquiring the initial "seed money." In some cases, largely dependent upon decisions of the State Medicaid/EPSDT agency, these costs can be offset through capitation made possible by certain waivers which may be granted by HCFA for purposes of initiating such a program. Pending Federal Legislation (the Child Health Assurance Program, CHAP), if passed, may serve to allieviate this problem.

Economies of scale also play a role in this regard: medically underserved areas exist in rural as well as urban areas, but the implementation of such programs in other than urban centers with high concentrations of Medicaid-eligible children is not fiscally attractive. A partial solution to this problem might exist through interagency agreements linking in such program as those for MCH and CCS programs funded under Title V of the Social Security Act, an the primary care programs such as community health centers under the Public Health Services Act.

A final problem is that of overcoming the barriers to school-based health programs that arise out of the typical resistance on the part of both the schools and the medical community to collaborate in the delivery of health services. Where such programs have become established, this problem has tended to resolve itself. In many other situations, it has prevented the establishment of such programs. It is required of both sides that they examine their separate interests in the context of their mutual commitments, and the potential benefits for needy children.

A final problem for schools wishing to participate in EPSDT is the administrative workload involved. Many school systems may not be organized to handle large-scale unit billing on a per-child/per service basis--a feature of Medicaid reimbursement procedures that is more common to medical practice and human resources agencies. In addition, certain requirements pertaining to records and reports (required in most states for program accountability)may be new to the typical school's data management experience. Potential resolutions to these problems maybe found through the 50% EPSDT match available for administrative costs, and through the 90% match for costs of developing the necessary data management systems.

A formal evaluation of the EPSDT/schools service delivery link has not yet been undertaken, although plans do exist to begin such an evaluation in the Fall of 1980. However, both health and education professionals have been able to identify a variety of benefits which arise out of this joint activity. Some of these are:

- Virtually all eligible school-aged children are enrolled in, or known to, the schools. The schools are therefore in a position to play a highly cost-effective role in linking these children to appropriate medical resources, whether through referral or direct provision of EPSDT services.
- Many of the features of the EPSDT outreach, screening, and follow-up activities are consistent with requirements of other federally funded programs in which schools may participate (e.g., the child find, IEP, and related services requirements of P.L. 94-142) which do not provide additional funds to meet the total costs of these added programs' requirements. Schools can, particularly in areas with high concentrations of Medicaid-eligible children, help defray these added costs through participation in the EPSDT program.
- In areas having a high density of medical resources, schools can fill gaps in outreach and referral services through minor extensions of then existing child find, IEP, and related services programs, while at the same time becoming more able to assure availability of related services through improved

linkages with the health community.

- Schools which effectively participate in EPSDT screening and/or diagnosis and treatment services will contribute significantly to the realization of community preventive health strategies through improved participation by the private and public health practitioners and through improvements in the health status of children.

- Schools which effectively participate in EPSDT screening and follow-up services may help to achieve greater efficency in the process of referring eligible children to a number of private physicians, thus preventing unnecessary overloading of individual private sector resources—a frequent barrier to accessability of needed medical services.

It is hoped that the benefits and barriers discussed in this guide will be thoroughly examined by school leaders, their health care system counterparts, and agents of relevant State and local agencies. It can be determined that schools have a vitally important and cost-beneficial role in solving some of the problems associated with providing high quality health services to Medicaid children.

APPENDICES

1. EPSDT Regional Coordinators
2. EPSDT State Coordinators
3. OE Regional Office Program Coordinators
4. Chief State School Officers
5. PHS Regional Program Consultants, MCH/CC
6. State MCH/CC Directors
7. HCFA Action Transmittals AT-78-2 and AT-78-46 (Interagency Agreement Guidelines)
8. Confidentiality Strategy (currently in draft form, to be published in Spring 1980)
9. HCFA Action Transmittal AT-79-101 (Reimbursement for EPSDT expenditures)

APPENDIX 1. EPSDT REGIONAL COORDINATORS

REGION I

Marla Kahn
HCFA, Medicaid
John F. Kennedy Bldg
13th Floor
Government Center
Boston, MA 02203
223-1467

REGION II

Ms. Tecla Kern
HCFA, Medicaid
Federal Bldg, Rm 3842
26 Federal Plaza
New York, NY 10007
264-2579

REGION III

Betty Wheeler
HCFA, Medicaid
10th Floor
P O Box 7760

36th and Market Sts.
Philadelphia, PA 19101
596-1322

REGION IV

Allie Saxon (AL, FL, GA, SC)
242-2081

Jerry McClain (KY, MS, NC, TN)
242-2562
HCFA, Medicaid
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VI	Earl P. Schubert, Director Office of Intergovernmental and Special Services Office of Education, Region VI 1200 Main Tower Dallas, Texas 75202 (214) 767-3711
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DIRECTORY OF CHIEF STATE SCHOOL OFFICERS

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izona egion IX)	Honorable Carolyn Warner Superintendent of Public Instr. Department of Education 1535 West Jefferson Phoenix, Arizona 85007 (602) 271-4361	Florida (Region IV)	Honorable Ralph D. Turlington Commissioner of Education Florida Department of Educatio Tallahassee, Florida 32304 (904) 488-3115
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lorado egion VIII)	Honorable Calvin Frazier Commissioner of Education State Department of Education Denver, Colorado 80203 (303) 839-2212	Hawaii (Region IX)	Honorable Charles G. Clark Superintendent of Education P.O. Box 2360 Honolulu, Hawaii 96804 (808) 548 6405
nnecticut egion I)	Honorable Mark R. Shedd Commissioner of Education State Department of Education Hartford, Connecticut 06115 (203) 566-[illegible]	Illinois (Region V)	Honorable Joseph M. Cronin State Superintendent of Educ. Illinois Office of Education [illegible] Springfield, Illinois [illegible] (217) 782-2221

ief State School Officers - cont.

STATE	CHIEF STATE SCHOOL OFFICER	STATE	CHIEF STATE SCHOOL OFFI
vada egion IX)	Honorable John R. Gamble Superintendent of Public Instr. Nevada State Depart. of Educ. St. Capital Complex Carson City, Nevada 89710 (702) 885-5700, EXT. 270	Oklahoma (Region VI)	Honorable Leslie R. Fisher Superintendent of Public Inst State Dept. of Education Oklahoma City, Oklahoma 731 (405) 521-3351
w mpshire egion I)	Honorable Robert L. Brunelle Commissioner of Education 410 State House Annex Concord, New Hampshire 03301 (603) 271-3144	Oregon (Region X)	Honorable Verne A. Duncan (State Super. of Public Instr. Oregon Department of Educati 942 Lancaster Drive, N.E. Salem, Oregon 97310 (503) 378-3573
w Jersey egion II)	Honorable Fred G. Burke Commissioner of Education State Department of Education Trenton, New Jersey 08625 (609) 292-4450	Pennsylvania (Region III)	Honorable Caryl M. Kline Secretary of Education Department of Education Post Office Box 911 Harrisburg, Pennsylvania (717) 787-5820
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APPENDIX 7: PUBLIC HEALTH/EPSDT INTERAGENCY AGREEMENT GUIDELINES

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GUIDE

ACTION TRANSMITTAL
HCFA-AT-78-2 (MMB)
January 13, 1978

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: MMB Medical Assistance Manual: Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

REGULATION REFERENCE: 42 CFR 451.10

ATTACHMENT: Revised Part 5 (Section 5-40-00) of the Medical Assistance Manual describing Interagency Relationships with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers.

MANUAL MAINTENANCE: Replace the current Part 5, Section 5-40-00 (originally issued as 5-30-00) with the attached revision.

INQUIRIES TO: Acting Regional Medicaid Directors

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MEDICAID INTERAGENCY RELATIONSHIPS

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Part 5 Services and Payments in Medical Assistance Programs

5-40-00 Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

5-40-10 Legal Background and Authority

A. Title XIX of the Social Security Act, as amended, Section 1902(a)(11)(A) and (B), and 1902(a)(20)(A), 1902(a)(22)(C)

B. 42 CFR 451.10

5-40-20 Implementation of Regulations

A. Purpose

Provision of medical care to the population eligible for medical assistance requires the participation of a majority of providers of medical services throughout the State. Medicaid must look to individual practitioners and to a variety of official and voluntary health agencies if services are to be available to all beneficiaries. To help assure availability to this population, many of whom have been medically underserved, title XIX, from its inception, has required the State agency to develop cooperative arrangements with the State health and vocational rehabilitation agencies.

The purposes of this guide are to:

- demonstrate the increasing emphasis which Federal, State and local agencies are giving to cooperation and collaboration in providing health services to individuals eligible for Medicaid services;

- emphasize the necessity of joint planning and decision-making among Federally-assisted health programs so that funds may be put to the best use in providing health services to Medicaid beneficiaries;

- present the essentials for Medicaid agency cooperative arrangements with other health, vocational rehabilitation and welfare programs;

- provide prototype information as to the scope and content of approvable inter-agency agreements;

- provide clearer answers to questions many State agencies have asked regarding cooperative arrangements; and

- provide a vehicle for better program management and evaluation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

These guidelines relate primarily to 42 CFR 451.10, concerned with relationships between Medicaid and State health, vocational rehabilitation, and Federally-funded health programs for women and children under title V of the Social Security Act. However, the principles and procedures in interagency cooperation are similarly applicable to the Medicaid agency's relationships with other health and social service agencies and organizations. Under Section 1902(a)(20)(A), the Medicaid agency must have an agreement with the State mental health authorities or individual mental institutions if the State Medicaid plan includes assistance to aged individuals in institutions for mental disease. Therefore, these guidelines cover relationships with a variety of Federally-assisted programs.

The guidelines also cover related issues, including: payment by Medicaid for services available without charge; Medicaid as a residual program; use of other medical services to which recipients have entitlement; freedom of choice of qualified provider; confidentiality; 75% matching for cost of skilled medical personnel; and transportation.

B. Background

When title XIX was enacted in 1965, it included a requirement for development of cooperative arrangements with State health and medical care agencies. Initially these were the State health department and the vocational rehabilitation agency and, when appropriate, the State mental health authority.

The 1967 amendments to the Social Security Act made the relationship between title V and Medicaid more explicit. Section 1902(a)(11) was revised to include a provision for Medicaid agreements with any "agency, institution, or organization" furnishing health services under title V. It also required provisions, as appropriate, for reimbursement of title V agencies by title XIX for services provided to Medicaid recipients. Section 513(c) of title V of the Act requires title V grantees to cooperate with the State Medicaid agencies in providing title V care and services to Medicaid eligibles.

42 CFR 449.10(a)(3)(i)-(iii) specifies State plan requirements for EPSDT services under Medicaid. They include: (1) the identification of available title V screening, diagnostic, and treatment facilities and services; (2) procedures to assure maximum utilization of these facilities and services; and (3) procedures for assuring that Medicaid recipients eligible for title V services are informed of such services and are so referred. All State Medicaid agencies have designated an individual or a unit to be specifically responsible for the administration of the EPSDT program.

C. Medicaid Relationships with the State Health Agency

State Medicaid plans must provide for maximum utilization of the services of State health agencies.

Effective implementation of Medicaid requires a close working relationship between the State health agency and the Medicaid agency.

Many programs of public health agencies can be helpful in meeting the needs of Medicaid recipients, for example:

- State and local health departments use maternal and child health funds to provide services in maternity clinics, child health clinics and immunization clinics. Some departments have dental programs, family planning services, mental health services and mental retardation clinics.

- Specialized public health staff can often assist the Medicaid agency in interpreting health services to recipients; in helping them use medical facilities; in follow-up; and in training welfare department staff on health problems, resources and care. Health agency staff resources include physicians, physician extenders, public health nurses, nutritionists, social workers and health educators.

- Other health department responsibilities that are related to the Medicaid program are comprehensive health planning and standard setting for health facilities and medical institutions. Because of the direct health services it provides and its responsibilities for State-wide planning, the State health agency must be represented on the Medical Care Advisory Committee of the Medicaid agency, where the health department is not itself the Medicaid agency (42 CFR 446.10).

- The 1972 amendments to the Social Security Act amended section 1902(a)(9) of the Act to spell out new roles for the State health agency or other appropriate State medical agency in relation to Medicaid. These include setting health standards for institutions, developing plans for professional review of services to recipients, and determining whether institutions and agencies meet requirements for participation in Medicaid.

D. Medicaid Relationships with State Title V Programs

State Medicaid plans must also provide for maximum utilization of the care and services available under title V programs.

Title V programs include a broad range of screening, diagnostic, treatment, and follow-up care and services available throughout the State under the Maternal and Child Health (MCH) and Crippled Children's Services (CCS) Programs, special projects for Mental Retardation (MR), Maternity and Infant Care (MIC), Children and Youth (C and Y), Family Planning, and Dental Health, plus a number of other special health service projects. All of these offer an important medical care resource for Medicaid recipients. Since maternal and child health services are administered by State health agencies, it is important that the Medicaid-health department agreement include a section on cooperative arrangements with the MCH Unit and, where applicable, the CCS Unit.

In 12 States, however, the CCS program is administered by an agency that does not have administrative authority over the MCH program; therefore, in these 12 States, an agreement must be drawn between the CCS agency and the State Medicaid agency.

EPSDT-Title V Relationships

The full scope of services authorized under Medicaid can be provided under EPSDT. The capacity to provide that full range of services can be developed by title V programs in the State in order to maximize the delivery of comprehensive health care services to EPSDT eligibles.

42 CFR 451.10 has particular relevance to title V and the EPSDT program. The compatability of these programs in early identification, diagnosis and treatment, case management and follow-up responsibilities should facilitate effective and efficient use of services and funds available under the two programs.

For maximum utilization of title V services for EPSDT eligibles, States can, therefore, consider providing under the State Medicaid plan all services for which Federal financial participation is available under title XIX, when screening and diagnosis indicate their necessity. This is possible because of the statutory exception for EPSDT to the requirement for comparability.

E. Medicaid Relationships with State Vocational Rehabilitation Agencies

State Medicaid plans must provide for written cooperative agreements with State vocational rehabilitation agencies (42 CFR 451.10).

5-40-00 Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

The Rehabilitation Act of 1973, as amended, and implementing Regulations require State vocational rehabilitation agencies to assist eligible handicapped individuals to enter, return to, or remain in gainful employment, through the provision of various services.

Many of the handicapped individuals eligible for services under this Act are also eligible for Medicaid.

Under the Rehabilitation Act of 1973 (Section 101(a)(8)) and implementing Regulations (45 CFR 1361.45(b)), the State vocational rehabilitation agency must give full consideration to any "similar benefits" available to a handicapped individual under any other program to meet in whole or in part the cost of certain services. Where Medicaid can provide physical and mental restoration services to a handicapped individual, this similar benefit provision would apply. Medicaid should be considered as an appropriate source of payment for these services and for diagnostic services.

The decisions about and the conditions under which Medicaid reimbursement is to be "first dollar" or residual are to be made by the State agencies involved and should be explicitly stated in the written agreement.

(See Section G-2 for an example of what may be included in written agreements).

F. Medicaid Relationships with Other Providers

In addition to State health and vocational rehabilitation agencies and title V programs, there are many other Federal and State-supported health programs that can serve as providers of medical care for Medicaid recipients. Among these are Head Start; Community Health Centers under section 330 of the Public Health Service Act; neighborhood health centers under various auspices; Appalachian Regional Commission (ARC) health and child development projects; migrant health centers; Indian Health Service facilities; Health Underserved Rural Areas (HURA) and Rural Health Initiative (RHI) projects; developmental disability projects; university affiliated mental retardation centers; and community mental health centers. Many of these can play a key role in Medicaid because they are organized to reach people who do not have easy access to health services or who seem uninformed or unmotivated and may need special help.

Although cooperation with these programs was not written into the title XIX law, as were the relationships with health, vocational rehabilitation and title V agencies, nevertheless, Medicaid policy requires State agencies to accept all qualified providers who agree to comply with program requirements. As the program with primary responsibility for health care to individuals eligible for Medicaid, the Medicaid agency has the same relationship to these programs as it does to any qualified provider. Medicaid can pay for the medical services they provide to recipients, within the limits of the State plan. Policies related to reimbursement, utilization review, medical review, and other administrative aspects of Medicaid apply to these programs just as they do to other providers. In addition to the usual provider agreement States may wish to negotiate comprehensive agreements as described in these guidelines.

G. Scope and Content of Interagency Agreements

1 - Parties to the Agreement

The appropriate parties to an interagency agreement that satisfies 42 CFR 451.10 will be found in a wide variety of organizational locations in each State.

Because of differing organizational arrangements and responsibilities, the respective State agencies must ensure that:

- Agreements are made between all relevant administering components of the State agencies and signed by responsible representatives.
- When Medicaid is administered by the Welfare department, there is an agreement with the State agencies for health, vocational rehabilitation and other relevant agencies when appropriate.

- When Medicaid is administered by a division of the health department, there are intra-departmental agreements with other divisions within the department concerned with health services and standards of care.

- When Medicaid, the public assistance program, public health services, and other human resources programs are part of an umbrella agency, agreements are developed with the appropriate units of the agency.

- When Medicaid is administered by a State agency which is independent of other State programs, an agreement is drawn up with all other relevant departments.

- Agreements are entered into by the respective State agencies that include provision for supplemental agreements with local administrative units, as necessary, in order to assure that services covered under the agreement are available, to the extent possible, on a statewide basis.

2 - Content of Interagency Agreements

Written agreements are essential to effective working relationships between the Medicaid agency and other agencies charged with planning, administering or providing health care to low-income families. Although agreements by themselves will not guarantee open communication and cooperation between agencies, they can lay the groundwork for collaborating to achieve the best utilization of each agency's resources.

5-40-00 Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

Agreements must be formal documents signed by each agency's representative or written statements of understanding between units of a single department. Whatever form they take, it is essential that the content be developed by all parties involved and that the document provide a clear statement of each agency's responsibilities for provision of medical care to Medicaid recipients.

Each agreement must specify the participating parties, the intent of the agreement, and the date upon which the agreement is to become effective, and must be signed by persons authorized to make the agreement binding.

Written agreements are useful for:

- providing a description of referral procedures that facilitate access to services without undue delay;
- specifying reimbursement arrangements, since Medicaid is increasingly looked to for payment of medical services provided by or through other agencies;
- exchanging reports of medical and social services for administrative purposes, planning with recipients, or providing services to them. When information is to be shared, the recipient's permission must be obtained for its release.

5-40-00 Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

To remain useful, agreements need periodic review to determine if they continue to be applicable to the organization, functions, and program of the participating agencies. This reevaluation needs to be done annually and whenever a major reorganization occurs within the agencies involved.

The specific content of each agreement will vary according to individual State arrangements on the roles and responsibilities of the parties to the agreement. However, using the EPSDT-Title V agreement as an example, the elements that are appropriate to most interagency agreements are described below, (see also 42 CFR 451.10(a)):

(a) Mutual Objectives and Respective Responsibilities of the Parties to the Agreement

State objectives in measurable terms, for example, expand State EPSDT-Title V activities from two counties to ten by the end of fiscal year 19___. In addition, this section may identify procedures for developing and producing "outcome" measurements of improvement in health status of children who received services, rather than just "output" measures of numbers of patients served or of specific procedures or tests given.

State responsibilities clearly so that both programs are aware of the specific items for which they are responsible, for example: in the case of EPSDT, the program that will maintain records of specific EPSDT screening services provided or the party responsible for post-screening referrals or arrangements for diagnosis and treatment.

(b) Arrangements for Early Identification of Individuals Under 21 Years of Age in Need of Medical or Remedial Care and Service

Include plans for informing individuals eligible for both EPSDT and title V services of available services and for referring them to title V grantees as appropriate (42 CFR 449.10(a)(3)(ii)). Specify referral criteria, for example: age groups, high-risk populations, diagnostic conditions, all EPSDT eligibles in specified counties, the services and title V programs or projects to which referral is appropriate.

Arrangements for early identification of need for medical or remedial care would include, at a minimum, provision for delivery of the State's EPSDT screening services according to the periodicity schedule established by the State.

(c) The Services Each Offers and in What Circumstances

List the services to be provided by each agency (indicating responsibility), and the circumstances (e.g., setting; for which populations) under which they will be offered. Where individual title V programs or projects are to provide services different from those made available Statewide under the agreement, describe the specific services.

(d) The Cooperative and Collaborative Relationships at the State Level

The overall agreement is designed to facilitate accessibility and availability of services on a Statewide basis. State the organizational location of the programs and which State offices, divisions, or other units will be responsible for coordinating title XIX-title V activities. It is particularly important to specify how the two agencies will resolve problems or issues and establish any necessary policies to carry out the agreement.

(e) The Kinds of Services to be Provided by Local Agencies

The title V program may include local grantees such as city or county health departments, in addition to individual projects such as M&I, C&Y, Child Development Clinics, etc. Specify the services to be provided by them, and the arrangements for these services.

(f) Arrangements for Reciprocal Referrals

Reciprocal referral arrangements should be developed between the title XIX-title V agencies so that individuals eligible for the services of both agencies/programs may be so informed and referred.

Indicate who has the responsibility for referrals, under what circumstances referrals are made, and who will have the follow-up responsibilities.

Numbers to be referred by the Medicaid agency to title V grantees will depend on the current title V capacity. In addition, Medicaid reimbursement can be used for expanding service capacity.

(g) Arrangements for Payment or Reimbursement

Specify:

- The providers, e.g., the State MCH or CCS agencies, or projects such as M&I, C&Y;
- To whom the payments will be made;
- mode of reimbursement, i.e., actual cost, customary charge, statistical visit rate, capitation, etc., and agreed-upon rates;
- reimbursement procedure including offices responsible for billing, payment and appeals;

- plans for use of Medicaid income earned by the title V grantee. Income may be used to expand existing services and/or initiate new programs under title V for low-income people.

(h) Arrangements for Exchange of Reports of Services to Medicaid Recipients

Specify what reports are needed; where they will be sent; how the data will be utilized; to whom the resulting information will be distributed; and at what intervals the reports will be completed.

(i) Methods to Coordinate Plans Relating to Medicaid Recipients

Indicate the frequency of planning sessions of the responsible units and the areas that will be included in mutual planning.

(j) Plans for Joint Evaluation of Policies

Describe in this section procedures for joint agency evaluation of policies that affect the delivery of services through title V to Medicaid eligibles, e.g., the scope of services covered under the title XIX State plan and the respective reimbursement rates payable by Medicaid and by title V for the services covered under the agreement. Provide for meetings, at least on an annual basis, to evaluate policies. Identify the units responsible for the evaluation, the periodicity of the evaluations, and how differences will be resolved.

(k) Arrangements for Periodic Review of the Agreements and Joint Planning for Changes in the Agreement

The responsible planning and evaluation units need to review the agreement to determine if it helps meet program goals or if changes in policy, budgets, laws, availability of resources, etc., require its revision. Specify in this section timing of review, responsible units, and procedures for making changes.

(l) Arrangements for Continuous Liaison and Designation of State and Local Liaison Staff

Describe the Medicaid-title V liaison units at the State and local levels and their responsibilities.

3 - Specific Content of Medicaid - Health Department Agreements

General Medicaid-health department agreements may cover specific arrangements for title V services in order to satisfy 42 CFR 451.10(a)(2), even though the health department may be the title V grantee. These arrangements may be detailed either in separate sections of the Medicaid-health department agreement or in separate agreements between Medicaid and the appropriate title V unit(s) within the health department. A "general" Medicaid agency-health department agreement is acceptable if it:

(a) includes financing and other elements that are the same for all programs under the jurisdiction of the health department, including the MCH/CCS programs, and

(b) states specifically that all such elements apply to those programs.

An agreement between the Medicaid agency and the health department (whether separate agencies or separate units within an umbrella agency) needs to specify whether the services/programs covered under the agreement are those funded by title V, or are provided under other funding and authorities available to the health department, or both.

Grants for family planning and dental health projects are made to State health agencies. Occasionally the grant goes directly to a local health department or other local agency. These projects should increase the availability of such services to Medicaid recipients, and the agreement with the State health agency would include such projects.

4. Specific Content of Medicaid-Title V Agreements, including EPSDT Agreements

Each State must have a title XIX-Title V agreement. It should be developed by those State agency representatives specifically responsible for administering the MCH, CCS and Medicaid (including EPSDT) programs.

Title XIX-title V agreements must be statewide in scope and should include a separate section on EPSDT activities. The agreement must include those title V services and related financing arrangements which are uniform in nature throughout the State and, where applicable, supplemental agreements for specific services and related financing arrangements that are not uniformly provided.

Specific reference is made in the Medicaid law to provision, as may be appropriate, for reimbursing title V agencies, institutions or organizations for the cost of services to Medicaid recipients. The intent of this provision is to make Medicaid funds the first and primary source of payment for medical services provided Medicaid recipients through title V programs. Interagency agreements should allow for the use of each agency's funds within the limits and administrative arrangements of each program.

Part 5 Services and Payments in Medical Assistance Programs

5-40-00 Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

Over two-thirds of the CCS programs throughout the country are administered by State health departments, and arrangements would, therefore, be covered in the basic health department-Medicaid agreement. Where CCS is administered by another State agency such as a special commission for the handicapped, a State welfare department, or a university medical school, separate agreements are needed with those agencies or organizations.

Maternity and infant care projects are intended to serve high risk prospective mothers and their infants in the first year of life. High risk refers to "any condition or any circumstance which increase the hazards to their health" (Social Security Act, Section 508)a)(1)). Projects for health of children and youth of preschool and school age in low-income areas provide comprehensive health services for young people who, because of economic or environmental circumstances, do not receive medical and related services. Mothers and children in public welfare families would qualify for care under both types of projects, and an agreement with the State health department or the State CCS agency is needed to cover such projects. Separate sections within the overall State agreement will be necessary when these projects are carried out under a local health department, medical school, teaching hospital, or non-profit private agency.

Agreements need to include not only the scope of medical services that are to be provided by title V grantees, but also related non-medical services that are to be provided by State and local operating agencies. These include such activities as ensuring or facilitating patient access to health services and allied health professionals; ensuring continuity and quality of care; and encouraging or promoting comprehensive evaluative procedures when appropriate.

The cooperative arrangements and the services that are to be provided by title V grantees are subject to mutual agreement by the respective agencies. They are to be described in the agreement in sufficient detail to allow for full understanding by both parties of each agency's responsibility for providing and paying for services to EPSDT-Medicaid eligible individuals.

States need to consider including in their interagency agreements the following elements to meet requirements of 42 CFR 451.10(a)(1) and (2) and 42 CFR 449.10(a)(3)(i)-(iii) for maximum utilization of State health and title V services for EPSDT eligibles:

- Arrangements for providing EPSDT services and related financing, including Statewide title V services and those that vary by program or project.

- Arrangements for title V programs and projects to provide to (or arrange for) EPSDT eligibles screening and related treatment and other Medicaid services under the plan. This will maximize continuity of care between initial and periodic screening episodes and acute care needs, and use of the full range of preventive and comprehensive care services provided by title V programs.

- Title V provision of non-medical services. Examples are: (1) resource development and coordination, (2) outreach activities, (3) case management procedures to assure completion of all stages from early identification through follow-up and after-care activities.

In this connection, if conditions described in Section 2-41-00 of this manual and SRS Action Transmittal 76-66 (4/20/76) are met, 75 percent Federal matching under Medicaid for EPSDT health-related support services is available.

B. Financing Arrangements

Effective financing arrangements between Medicaid and the other State agencies can facilitate the development, organization and implementation of health care services for Medicaid recipients. Decisions about financing arrangements and reimbursement for services to Medicaid recipients should be worked out between the responsible agencies to make the most effective use of funds of all programs. However, the statute has given special emphasis to the use of Medicaid funds as a first dollar resource by title V.

Medicaid funds may also be used as a first dollar resource for services provided by vocational rehabilitation and certain other programs and projects (see section I-1). However, payment benefits from other hospital or health insurance, or other third parties which are under obligation to provide such benefits for Medicaid eligibles, must be used before drawing on Medicaid funds.

If Medicaid funds are to be used for payment of medical services, fee schedules must be established and all third parties must be billed for services covered under the agreement for which they are liable. Financing arrangements can include: a) reimbursement on the basis of fee-for-services, per-patient-visit, per-clinic-visit, and b) prepayment methods.

The State Medicaid agency may pay title V grantees, Head Start grantees and others as "providers". In such instances, Medicaid payment is payment in full and the grantee may not bill another party for additional amounts.

When a grantee is a "provider" for Medicaid purposes, Medicaid (1) is not involved in payment the grantee negotiates with its own providers; and (2) cannot require that the grantee's providers have Medicaid agreements. The grantee's payment to its provider may be higher than that which it has received from Medicaid so long as it accords with the upper limits for its own programs.

Part 5 Services and Payments in Medical Assistance Programs

5-40-00 Interrelations with State Health and Vocational Rehabilitation Agencies, with Title V Grantees and with other Providers

A "provider" under Medicaid, other than the grantee, who furnishes services under a grantee program or project and receives payment directly from Medicaid, must accept the Medicaid payment as payment in full and may not bill the grantee.

Cost reporting systems are needed to determine the cost of providing specific types and units of services to Medicaid eligibles.

I. Related Issues

The interrelationships regulation calls attention to several related issues growing out of other regulations or involving questions of public assistance philosophy.

1. Medicaid as a Residual Program Along with other public assistance programs, Medicaid is considered a residual program. As such, it is intended to be a resource only after other sources of medical care have been tapped. However, greater flexibility exists in the medical assistance program than is possible in financial assistance programs. Other Federally-funded programs may have a higher residual rating than Medicaid. They are generally closed-

ended and time-limited. These include such programs as Head Start, comprehensive health services projects, migrant health projects, Appalachian Regional Commission (ARC) health and child development projects, and Health Underserved Rural Areas (HURA) projects. Medicaid funds are to be used for services to Medicaid recipients provided under these programs and covered by the State plan. This is often referred to as the "first dollar" concept. It places on Medicaid the responsibility for using its funds up to the limits of the State plan on scope and amount of services, before looking to other programs to pay for medical care provided to Medicaid recipients.

2. Entitlement to Medical Care If Medicaid recipients are entitled to benefits from such sources as Medicare, CHAMPUS, VA medical services, or other hospital or health insurance, they must use these benefits before drawing on title XIX.

3. Payment for Services Available Without Charge From the outset, Medicaid has held to the principle that Medicaid funds may not be used for services that are free to everyone in the community. In this context, the word "community" is used variably. It may represent a State, a portion of the State, a city, or a particular classification of the population such as all

school children. Some examples of services available without charge are public health services, school health programs, tuberculosis, venereal disease and other case-finding programs. Services available without charge, for purposes of Medicaid, means that no individual or family is charged for medical care, and third party reimbursement is not sought.

As third party payments have become available, agencies and organizations that provided services available without charge in the past now look to third party payors as one source of program support. The Medicaid agency is considered to be a "third party." Title V regulations provide for charging third parties (including government agencies) which are authorized or under legal obligation to pay for any service provided by the title V grantees, including preventive, diagnostic, and treatment services, even though the service may otherwise be provided without charge to the patient or family. Where the cost of services furnished by or through the program or project is to be reimbursed under Medicaid, a written agreement with the title XIX agency is required. This must specify whether reimbursement is to the project or directly to the provider.

The emphasis of the 1967 title XIX amendment on payment for title V services and the revision of title V regulations to charge third party payors increased the original Medicaid responsibility to pay for title V services to Medicaid recipients.

4. Freedom of Choice Since July 1, 1969, Medicaid recipients have had the right to exercise freedom of choice of providers (Section 1902(a)(23); 42 CFR 449.20; Manual Chapter 5-100-00). This requirement does not conflict with the amendment's reference to "maximum utilization" of services of the State health and vocational rehabilitation agencies. Freedom of choice means that the client is informed about the choices available and is free to select a provider who is willing to accept Medicaid patients. The State agency carries out its responsibilities by negotiating inter-agency agreements and informing recipients about State health, vocational rehabilitation, title V and other programs.

5. Confidentiality Federal policy (Section 1902(a)(7) of the Social Security Act and 45 CFR 205.50(a)) prohibits the use or disclosure of information, including lists of names and addresses, concerning applicants and recipients of services

without their informed consent, except for purposes directly connected with the administration of the program. This general prohibition applies to disclosure of information to service providers, without exception, since they are not considered to be directly connected with the administration of the program. State and local agencies must ensure, therefore, that they comply with Federal policy and that all such information remains confidential.

6. 75% Federal Matching 75% Federal matching is available for cost of skilled professional medical personnel and staff directly supporting such personnel employed by the title XIX agency, or by any other public agency if they assist in the administration of the Medicaid program at the State and local level (42 CFR 446.175 and Manual Chapter 2-41-00). This special matching rate is available only for those portions of time directed to the administration of the Medicaid program.

   Functions or services performed or provided by another public agency for Medicaid recipients which are not required by Medicaid are not subject to Federal matching under Medicaid.

7. Transportation Under the requirement in 42 CFR 449.10(a)(5)(ii), a State Medicaid plan must contain a commitment to assure necessary transportation of eligible recipients to and from providers of services, and a description of the methods to be used. This requirement relates to the availability of transportation as an administrative aid in carrying out the provision of medical services, and Federal matching is available at the administrative rate. State agencies have an obligation to pay for transportation only if it is not otherwise available to the recipient.

In order to comply with this requirement, State agencies may and do use a variety of methods. In addition to the administrative requirement, States have the option of providing for some transportation as an item of medical assistance, and may claim Federal matching at the Federal medical assistance percentage. (See Manual Chapter 6-20-00).

APPENDIX 8. CONFIDENTIALITY STRATEGY

(AVAILABLE SPRING 1980)

APPENDIX 9. REIMBURSEMENT PROCEDURES

BALTIMORE, MARYLAND 21235

ADVANCE COPY

POLICY INTERPRETATION

ACTION TRANSMITTAL
HCFA-AT-79-101 (OCH)
October 30, 1979

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Medical Assistance Manual: State Organization; Staffing for Administration; Federal Financial Participation; Implementation; Staff of Other Public Agencies

REGULATION REFERENCE: 42 CFR Part 432 ff

ATTACHMENT: Clarification of circumstances under which 75 percent FFP is available for salary and other costs of skilled professional medical personnel and staff of public agencies providing direct support to the Medicaid agency in the administration of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and other title XIX programs.

The purpose of this Action Transmittal is to facilitate development and modification of agency agreements for the delivery of EPSDT services to Medicaid recipients and to define more clearly the methods for meeting requirements and penalty provisions of the EPSDT regulation published May 18, 1979. (42 CFR Part 441, subpart B)

The general requirements contained herein, relating to skilled professional medical personnel and staff directly supporting such personnel, are also applicable to Medicaid agencies. This revised policy supersedes previously existing interpretations contained in MSA PRG 32 and SRS AT-75-50, and other prior policy issuances inconsistent with this policy.

EFFECTIVE DATE: October 1, 1979

MANUAL MAINTENANCE: Replace p. 20 of section 2-41-20 of the Medical Assistance Manual with the attached pp. 20-25.

ACTION ITEM: Amend Subpart E to read "Staff of Other Public Agencies - General

INQUIRIES TO: Regional Medicaid Directors

Leonard D Schaeffer

Leonard D. Schaeffer
Administrator

①

Part 2 State Organization

2-41-00 Staffing for Administration, Federal Financial Participation

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F. Staff of Other Public Agencies - General (cont.)

facilities; and maintain historical records identifying services provided to each child participating in the program.

Another example would be use of the Department of Public Health to review the utilization of title XIX services.

It should be noted that personnel of such other agencies must meet the requirements described for skilled professional medical personnel and staff directly supporting such personnel in order to be eligible for 75 percent FFP. (See Staff of Other Public Agencies - EPSDT)

G. Staff of Other Public Agencies - EPSDT

Under the EPSDT program, 75 percent FFP would be applicable if the following requirements are met:

1. Skilled Professional Medical Personnel

   Skilled medical professionals include: physicians, dentists, other health practitioners, nurses, medical social workers, health educators and, other specialized personnel in the field of medical care including medical administrators, hospital or public health administrators, and licensed nursing home administrators.

   a. The skilled medical professional must be an employee of the public agency at the State or local level.

   b. The skilled medical professional must be identifed by interagency or intragency agreement to provide:

      (1) direct assistance to the skilled medical professional employed by the title XIX agency
      OR
      (2) direct assistance to the title XIX agency in the administration of health related services in support of EPSDT.

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G. Staff of Other Public Agencies - EPSDT (cont.)

c. The skilled medical professional must perform, supervise, or be ultimately responsible for health-related administrative services in support of EPSDT.

d. The skilled medical professional who supervises or is ultimately responsible for functions performed by non-professional supporting staff must:

(1) define their positions and functions to be performed
(2) provide for their training
(3) monitor and evaluate their activities.

2. Staff Supporting Skilled Professional Medical Personnel

a. The staff must be employed by the public agency at the State or local level.

b. The staff must be identified by interagency or intra-agency agreement to provide:

(1) direct assistance to the skilled medical professional employed in the public agency

OR

(2) direct assistance to the skilled medical professional employed in the title XIX agency, in which case no skilled medical professional is required in the public agency.

c. The staff must perform health-related administrative services in support of EPSDT.

d. The staff must be supervised or under the ultimate responsibility of a skilled medical professional, employed either by the public agency or the title XIX agency.

(4)

2-41-00 Staffing for Administration, Federal Financial Participation

2-41-20 Implementation

G. Staff of Other Public Agencies - EPSDT (cont.)

3. EPSDT Administrative Services

The skilled medical professional and supporting staff must perform or supervise health-related administrative services in support of EPSDT. The specific services may be determined by each State based on its administrative structure, capacity for program operation and available resources.

a. Outreach - Actions taken by a public agency at the State or local level to assure that families are informed about the EPSDT program, are helped to understand its importance, and are encouraged and assisted to seek EPSDT services from available health care resources and providers of medical care. Outreach efforts include all of the following agency and staff requirements:

(1) Agency Requirements

(a) Approved interagency or intragency agreement with the title XIX agency, specifying:

- The mutual objectives and responsibilities of each party to the arrangement;
- The services each party offers and in what circumstances;
- The cooperative and collaborative relationships at the State level;
- The kinds of services to be provided by local agencies; and
- Methods for (as appropriate)-
  - Early identification of individuals under 21 in need of medical or remedial services;
  - Reciprocal referral;
  - Coordinating plans for health services provided or arranged for recipients;
  - Payment or reimbursement;
  - Exchange of reports of services furnished to recipients;

Part 2 State Organization

2-41-00 Staffing for Administration, Federal Financial Participation

2-41-20 Implementation

G. Staff of Other Public Agencies - EPSDT (cont.)

.. Continuous liaison between the parties, including designation of State and local liaison staff; and

.. Joint evaluation of policies that affect the cooperative work of the parties.

(b) Procedures for informirg families consistent with regulation requirements and State informing requirements

(c) Procedures to link the family requesting EPSDT services to the title XIX agency or the appropriate referral or service delivery system

(d) Procedures for recording and reporting the requests of families (and documentation data) to the title XIX skilled medical professional or the title XIX agency

(e) Procedures and training standards for staff performing the outreach functions

(f) Time sharing/cost allocating procedures for reimbursement under title XIX

(2) Staff Requirements

All of the items listed below are required under 42 CFR 441.75

(a) Face-to-face contact and distribution of written material by trained personnel who can explain EPSDT services and benefits. The explanation must include:

2-41-20 Implementation

C. Staff of Other Public Agencies - EPSDT (cont.)

- The benefits of preventive health services;
- How EPSDT services can be obtained;
- How specific information can be obtained on the location of the nearest providers participating in EPSDT;
- The screening services that the title XIX agency offers under its plan;
- A summary of the State's periodicity schedule;
- That recipients can receive both initial and periodic screening according to the State's periodicity schedule;
- That treatment services covered under the title XIX plan will be provided for problems disclosed during screening;
- That assistance in referral will be given for services not covered under the title XIX plan;
- That the title XIX agency will provide assistance with transportation to the extent covered under its plan, if the family or recipient requests it;
- That the title XIX agency will assist in scheduling appointments if the family or recipient requests this assistance;
- That as long as the family or recipient remains eligible for AFDC, it may request EPSDT services at any time in the future if it chooses to postpone its decision at the time it is initially informed;
  - That the family or recipient may choose to receive EPSDT services from a provider of its choice; and
  - That if the provider does not offer the full range of EPSDT services as specified in the title XIX plan, the family or recipient can receive the services not offered if the family or recipient requests them from the agency; and
- That the EPSDT services covered under the title XIX plan are available at no cost.

(7)

2-41-20 Implementation

C. Staff of Other Public Agencies - EPSDT (cont.)

(b) An explicit offer of EPSDT health care and related support services must be made and a response solicited. Documentation must be made of the date of offer, the specific response, and the date of request or declination.

Public agencies responsible for title IV A, title XX, Education programs, etc., who meet the above requirements may claim the 75 percent FFP for those portions of time spent in the administration of health-related administrative services in support of EPSDT. The functions or services performed or provided by the public agency for Medicaid recipients which are not required by Medicaid are not subject to Federal matching under Medicaid.

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